See Attached DD Form 2005
For Privacy Act Statement

PATIENT SCREENING FORM

Please complete questions 1 through 14 and return to Health Care Team.		
PLACE A CHECK IN THE YES OR NO COLUMN AND UPDATE <u>EVERY</u> VISIT *(Please Use Pencil)*	**YES**	**NO**
1. Has it been more than a year since you completed a "How's Your Health" Survey (HYH)		
2. Primary Language:		
3. Are you experiencing pain at this time?		
4. Do you need any educational information today?		
5. What method(s) of learning do you prefer? (Select all that apply) ☐ One-on-One Instruction ☐ Group Instruction ☐ Reading ☐ Videos ☐ Demonstration ☐ Other:		
6. Do you have any medical problems that make it difficult for you to understand medical information or instructions?		
7. Learning Barriers: (Select all that apply) ☐ Hearing ☐ Vision ☐ Speech ☐ Cultural ☐ Motivation ☐ Religious ☐ None ☐ Other:		
8. Do you have any religious customs, beliefs or rituals that may affect your medical care?		
9. Are you taking any dietary supplements, herbal medications or vitamins?		
10. Have you experienced a 10-pound or more change in weight in the past 6 months?		
11. Do you have a medical problem that effects what you can eat?		
12. Do you have difficulty chewing or swallowing foods or liquids?		
13. Would you like to discuss nutritional issues with a dietitian?		
14. Do you have any problems performing your activities of daily living? (Activities such as dressing, feeding, grooming or bathing yourself or walking)		

SIGNATURE OF PATIENT:	DATE:

PATIENT, PLEASE RECHECK & COMPLETE WITH EACH VISIT

Has Your Information on This Form Changed Since Your Last Visit? Select ONE **YES** Information Has Changed **No** Information Has Not Changed		Patient Initials	Date

RETURN FORM TO HEALTH CARE TEAM

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name – last, first, middle; ID No. or SSN; Sex; Date of Birth; Rank/Grade.)*

WRAMC FORM 716
Jul 02

CONSULT(s): SELECT/ LIST TYPE & DATE SENT:

☐ Dietary _____☐ Pharmacy_____

☐ Wellness Center_____ ☐ P.T. _____

☐ O.T. _____

☐ Other:_____

☐ Other:_____

☐ Other:_____

PROVIDER RECHECK & COMPLETE WITH EACH PATIENT VISIT

DATE	PROVIDER SIGNATURE	REMARKS/CONSULTS SENT

Maintain this form on inner left side of Outpatient Record

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name – last, first, middle; ID No. or SSN; Sex; Date of Birth; Rank/Grade.)*